Benefits summary:

PriorityHealth

PriorityHSA POS 1400 - Gold

Beginning on or after 01.01.2019

This document is intended to be an easy-to-read summary to provide a general overview of your benefits. It is not a contract or legal document. Additional limitations and exclusions may apply to covered services. This plan has a specific network of providers, so check the Provider Directory prior to receiving services. Prior authorizations for certain services may apply. A complete description of benefits is contained in the Certificate of Coverage, Schedule or Agreement as applicable.

Member cost-sharing	Tier 1 (in-network)	Tier 2 (out-of-network)
Deductible *The amount you pay before we begin to pay.*	$1,400 individual/$2,800 family aggregate	$2,800 individual/$5,600 family aggregate
Coinsurance *Your share of the costs of a covered health care service.*	10% coinsurance for in-network services after deductible is met, except where noted.	30% coinsurance of R&C (reasonable & customary) for out-of-network services after deductible is met, except where noted.
Coinsurance maximum *The most coinsurance cost share you'll pay for covered services in a contract year. Your coinsurance cost share counts toward your out-of- pocket maximum.*	N/A	N/A
Out-of-pocket maximum *The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.*	$3,500 individual/$7,000 family aggregate	$7,000 individual/$14,000 family aggregate

Office visits	Tier 1 (in-network)	Tier 2 (out-of-network)
Primary care provider (PCP)	10% coinsurance after deductible	30% coinsurance of R&C after deductible
Specialists	10% coinsurance after deductible	30% coinsurance of R&C after deductible
Urgent care	10% coinsurance after deductible	30% coinsurance of R&C after deductible
Virtual visits *24/7 care for non-emergency conditions*	Covered in full after deductible	30% coinsurance of R&C after deductible
Allergy testing, serum and injections	10% coinsurance after deductible	30% coinsurance of R&C after deductible
Retail health clinic *Located in a retail center, like a supermarket or pharmacy and provides care for common illnesses and services (examples: ear aches, sore throats, flu shots)*	10% coinsurance after deductible	10% coinsurance of R&C after deductible

Mental and behavioral health	Tier 1 (in-network)	Tier 2 (out-of-network)
Inpatient hospital	10% coinsurance after deductible	30% coinsurance of R&C after deductible

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Outpatient office visits	10% coinsurance after deductible	30% coinsurance of R&C after deductible
Prescription drug coverage *Visit **priorityhealth.com** and search **Approved Drug** list to see a list of covered drugs and pricing information.*		
Generic	$5 preferred generic / $20 non-preferred generic copayment, after deductible	Not covered
Brand	$60 preferred brand copayment / $80 non-preferred brand copayment, after deductible	Not covered
Specialty	20% coinsurance up to a maximum copayment of $250 per fill for preferred and $450 per fill for non-preferred after deductible	Not covered
Preventive care	**Tier 1 (in-network)**	**Tier 2 (out-of-network)**
Preventive care, immunizations	Covered in full; includes women's preventative health care services, well-child visits, flu shots and routine physical exams. Get the most up-to-date list of all the care that's recommended in our Preventative Health Care Guidelines when you login to your online account at priorityhealth.com	30% coinsurance of R&C after deductible
Laboratory and X-ray	**Tier 1 (in-network)**	**Tier 2 (out-of-network)**
Radiology	10% coinsurance after deductible	30% coinsurance of R&C after deductible
Advanced imaging (CT/ PET/MRI)	10% coinsurance after deductible	30% coinsurance of R&C after deductible
Laboratory	10% coinsurance after deductible	30% coinsurance of R&C after deductible
Emergency Services	**Tier 1 (in-network)**	**Tier 2 (out-of-network)**
Emergency room	10% coinsurance after deductible	Covered at in-network benefit
Emergency transportation/ ambulance services	10% coinsurance after deductible	Covered at in-network benefit
Hospital care	**Tier 1 (in-network)**	**Tier 2 (out-of-network)**
Inpatient hospital physician services	10% coinsurance after deductible	30% coinsurance of R&C after deductible
Surgery and/or facility fee	10% coinsurance after deductible; exceptions apply	30% coinsurance of R&C after deductible
Bariatric surgery	50% coinsurance after deductible; covered once per lifetime	50% of R&C coinsurance after deductible; covered once per lifetime
Outpatient Care	**Tier 1 (in-network)**	**Tier 2 (out-of-network)**
Skilled nursing or critical services	10% coinsurance after deductible; combined maximum 45 visits per member each contract year	30% of R&C coinsurance after deductible; combined maximum 45 visits per member per contract year
Outpatient surgery	10% coinsurance after deductible	30% of R&C coinsurance after deductible
In-home and hospice care	10% coinsurance after deductible	30% of R&C coinsurance after deductible
Rehabilitation services and devices	**Tier 1 (in-network)**	**Tier 2 (out-of-network)**
Physical and occupational therapy (including chiropractic)	10% coinsurance after deductible; combined maximum 30 visits per member per contract year	30% of R&C coinsurance after deductible; combined maximum 30 visits per member per contract year
Speech therapy	10% coinsurance after deductible; 30 visits per member per contract year	30% R&C coinsurance after deductible; combined maximum 30 visits per member per contract year
Prosthetic and orthotic support	50% coinsurance after deductible	50% of R&C coinsurance after deductible
Durable medical equipment (DME)	50% coinsurance after deductible	50% of R&C coinsurance after deductible

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Family planning and maternity care	Tier 1 (in-network)	Tier 2 (out-of-network)
Family planning	50% coinsurance after deductible	Not covered
Routine prenatal and postpartum care	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services.	30% of R&C coinsurance after deductible
Maternity delivery and nursery care	10% coinsurance after deductible	30% of R&C coinsurance after deductible
Tubal ligation	Covered in full for physicians services and outpatient facility Note: Hospital inpatient care facility charges are subject to deductible and coinsurance when in connection with delivery or other covered inpatient surgery	30% of R&C coinsurance after deductible
Vasectomy	10% coinsurance after deductible	Not covered

Additional Benefits

Cost estimator: Calculates specific costs for hundreds of procedures, based on where you're at with your deductible, coinsurance, etc. If a selected procedure is above fair market price, the tool will provide a list of nearby facilities where it's offered at a lower cost.

Travel assistance: If you become ill or injured while traveling more than 100 miles from home,
AssistAmerica® coverage is included in your plan. Receive help with medical care, coordinating
prescriptions, assistance with lost luggage, and even arrange your travel back home.

Member perks: Earn up to 20% cash back when you purchase digital gift cards from

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